

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/29/2012
FORM APPROVED
OMB NO. 0938-0391

Poc #1 OTC 10/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2012
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NAME OF PROVIDER OR SUPPLIER

BROOKHAVEN MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

2035 STONEBROOK PLACE

KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure privacy during treatment for one (#2) of eight residents reviewed.</p>	F 164	<p>F164</p> <p>Corrective action(s) accomplished for those residents found to have been affected:</p> <p>Resident #2 on 08/20/12 at 8:50 am upon observation privacy curtain was then pulled around resident and the door was closed for completion of the skin check. How other residents having the potential to be affected were identified and correction action(s) accomplished: All residents have same potential to be affected. On 08/20/12 on 9:30 am and throughout the day DON made rounds on all units and observed privacy curtains being pulled and doors shut during resident care and treatments. No dignity issues were observed. Measures or systematic changes put into place to ensure the deficient practice does not recur: Dignity/Privacy training provided to the treatment nurse on 08/21/12 at 11a per the DON. 100% of all staff in-service on Quality of Life - dignity beginning on 08/21/12 per the DON. Training to be completed by 09/30/12. In-service will be added to the new employee orientation packet. Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur: DON or ADON will conduct observations of resident care/tx 5 residents per week x 8 weeks to assure that each resident is cared for in a manner that promotes dignity and respect, beginning on 08/21/12. Monthly findings will be submitted to the Quality Assurance Committee who will determine need for future focus.</p>	9/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jonathan Hicks / med

Administrator

9/14/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(per Signed Licensure page)

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F 164	<p>Continued From page 1</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on August 14, 2012 with diagnoses including Anxiety, Severe Diverticulosis, Gastrostomy Tube (G-tube for feeding), Hypertension, Benign Prostatic Hypertrophy, Fractured Femur with Open-Reduction Internal Fixation, Atrial Fibrillation and Dysphagia.</p> <p>Medical record review of an initial nursing assessment dated August 14, 2012 revealed the resident was alert; had short and long-term memory impairment and severely impaired decision-making skills; had skin tears to the right elbow and wrist, a surgical incision on the right hip, a scab on the left great toe and bruising.</p> <p>Observation of the resident in the resident's room for a skin check with Licensed Practical Nurse (LPN) #1/Treatment Nurse and Interview on August 20, 2012 at 8:40 a.m. revealed LPN #1 did not close the door to the resident's room but did pull the privacy curtain to the door to provide privacy from staff, other residents or visitors in the hallway. Observation revealed the LPN did not fully pull the privacy curtain around the resident. Observation revealed the alert and oriented roommate was in a wheelchair in the room; moving back and forth in full view of resident #2; and stated "He (resident #2) gets more attention than I do." Observation revealed Certified Nursing Assistant (CNA) #1 was assisting the roommate at the sink in view of resident #2. Observation revealed resident #2 was lying in bed with Oxygen (O2) at 2 liters per minute via nasal cannula. Observation revealed Jevity 1.2 cal (calories) at sixty milliliters per hour</p>	F 164		

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F 164	Continued From page 2 via the G-tube. Continued observation revealed an abdominal binder in place over the G-tube. Observation revealed both legs were wrapped in gauze. Interview with LPN #1 revealed the legs were "swollen and draining-seeping from both legs." Continued observation revealed a healing wound to the left great toe. Interview on August 20, 2012 at 8:48 a.m. in the resident's room with LPN #1/Treatment Nurse confirmed the privacy curtain was not pulled around the resident to provide privacy from the roommate during the skin check. Interview on August 20, 2012 at 8:50 a.m. with CNA #1 confirmed the door to the room was not closed during the observations. Continued Interview confirmed if the privacy curtain was pulled completely around the bed of resident #2 "It leaves a gap at the door so anyone walking by could see" the resident. Continued interview confirmed the privacy curtain was not pulled and the roommate had full sight of the resident during the observations.	F 164			
F 311 SS=D	C/O #29207, #29341 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure sufficient and	F 311	F311 Corrective action(s) accomplished for those residents found to have been affected: Resident #5 was discharged from the facility on 02/20/12. How other residents having the potential to be affected were identified and corrective action(s) accomplished: On 09/12/12 dietary manager reviewed 100% resident dietary orders for accuracy.	9/30/12	

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F 311	<p>Continued From page 3</p> <p>appropriately trained staff were available to maintain or improve eating abilities and failed to provide the appropriate food form for one resident (#5) of eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on February 14, 2012 with diagnoses including Fractured Tibia and Fibula with Open Reduction and Internal Fixation (February 1, 2012), Osteoporosis, Hypertension, Mental Retardation, Paralysis Agitans, Anxiety Disorder, Depressive Disorder, Parkinson's Disease and History of Colon Cancer.</p> <p>Medical record review of the Minimum Data Set (MDS) dated February 20, 2012 revealed the resident had severely impaired decision-making skills; was totally dependent on staff for all activities of daily living (ADL) except for eating; and had coughing or choking during meals or when swallowing medications and required a mechanically altered diet.</p> <p>Medical record review of the physician's orders dated February 14, 2012 revealed the resident received a regular diet.</p> <p>Medical record review of a speech therapy screen dated February 15, 2012 revealed "...observed eating lunch with sitter at bedside...had no problem chewing...food, but...needed cues to eat slowly and to take one bit at a time. During this time...POA (Power of Attorney) was told that we do not allow private sitters at (facility)...pt (patient) was placed in restorative dining so...could be supervised at mealtime. Dietary was given a</p>	F 311	<p>F311 cont.</p> <p>Physician diet orders were compared against the dietary tray card and the monthly physician orders. On 09/12/12, ST reviewed all residents that are presently on ST case load for accuracy and to assure order is appropriate for resident to maintain or improve eating ability.</p> <p>Measures or systematic changes put into place to ensure the deficient practice does not recur:</p> <p>All CNA's, RN's, LPN's and therapy staff beginning on 09/12/12 and ongoing have completed a checking (Obstructed Airway Clearance) competency. The competency check-off is being completed per the Risk Manager, DON or ADON. Will be completed by 09/30/12.</p> <p>Daily review of all dietary orders per the DON, ADON or RN supervisor to assure all orders are appropriate for resident to maintain or improve eating ability.</p> <p>Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:</p> <p>Dietary manager will verify any diet change order with the DON or ADON to assure the diet order is appropriate for resident to maintain or improve eating ability.</p> <p>Dietary manager will audit 15 trays per week x 8 weeks to assure diet served is accurate per MD orders. Findings will be submitted to Quality Assurance Committee on a monthly basis. The committee will determine the need for future focus.</p>				

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F 311	<p>Continued From page 4</p> <p>dietary communication form on diet (change) to soft mech (mechanical)-chopped meat...Placed in restorative dining..."</p> <p>Medical record review of a document entitled "Rehab. Services Recommendations For;" dated February 15, 2012 revealed "...Restorative Nursing Program...eats too fast...will choke if...puts too much food in...mouth...diet is soft mech-chopped-no nuts, no food with peeling...Instructions...watch pt at mealtime...If you leave...put tray aside & (and) then give back...Keep a visual eye on...at all times...3 times a day for 12 wks (weeks)..."</p> <p>Medical record review of a speech therapy screen dated February 16, 2012 revealed "...reported by CNAs (Certified Nursing Assistants) & restorative aids that (resident) has not had any episodes of choking and...doing well on soft mech-chopped meats and supervision at meals..."</p> <p>Medical record review of a speech therapy screen dated Friday, February 17, 2012 revealed "... (Diet change) for the weekend...decided to change (resident's) meat to puree for the weekend because restorative does not work on the weekend...to be in dining room for all meals with supervision. Pt's meat was changed because that seems to be the food that...crams into...mouth...On Monday I will change diet back to soft mech-restorative will be back on Monday (February 20, 2012)..."</p> <p>Medical record review of a nurse's note dated February 20, 2012 revealed the family discharged the resident to the home with plans for home health services.</p>	F 311			

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F 311	Continued From page 5 Telephone interview on August 21, 2012 at 12:10 p.m. with the Speech Therapist (ST) confirmed the ST had been informed the resident had "tendencies to choke at home" on meat and the ST "felt it was more appropriate at the nursing home to put...on chopped meat." The ST confirmed the resident required no assistance with eating but would place a "lot of meat on the spoon" and required supervision with eating. Continued interview revealed the restorative staff reported the resident "did really good if they sat with (resident)." Continued interview revealed the facility reduced restorative staffing from seven to five days a week-Monday through Friday, and the ST "was afraid...might get choked..." if left on a mechanical diet over the weekend. Continued interview confirmed the resident was placed on a puree diet for the weekend because the facility did not have restorative staff available, and the ST planned to resume a soft mechanical diet on Monday, February 20, 2012.	F 311			
F 365 SS=D	C/O #20341 483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide food in a form to meet one resident's (#5) needs of eight residents reviewed.	F 365	F365 Corrective action(s) accomplished for those residents found to have been affected: Resident #5 was discharged from the facility on 02/21/12. How other residents having the potential to be affected were identified and corrective action(s) accomplished: Dietary manager audited 100% resident diet orders for accuracy - compared physician order against tray card. Completed on 09/12/12. On 09/12/12 Speech therapist reviewed all residents receiving speech therapy services to assure current dietary order is accurate and appropriate for resident to maintain or improve eating ability.	9/30/12	

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F 365	<p>Continued From page 6</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on February 14, 2012 with diagnoses including Fractured Tibia and Fibula with Open Reduction and Internal Fixation (February 1, 2012), Osteoporosis, Hypertension, Mental Retardation, Paralysis Agitans, Anxiety Disorder, Depressive Disorder, Parkinson's Disease and History of Colon Cancer.</p> <p>Medical record review of the Minimum Data Set (MDS) dated February 20, 2012 revealed the resident had severely impaired decision-making skills; was totally dependent on staff for all activities of daily living (ADL) except for eating; and had coughing or choking during meals or when swallowing medications and required a mechanically altered diet.</p> <p>Medical record review of the physician's orders dated February 14, 2012 revealed the resident received a regular diet.</p> <p>Medical record review of a speech therapy screen dated February 16, 2012 revealed "...observed eating lunch with sitter at bedside...had no problem chewing...food, but...needed cues to eat slowly and to take one bit at a time. During this time...POA (Power of Attorney) was told that we do not allow private sitters at (facility)...pt (patient) was placed in restorative dining so...could be supervised at mealtime. Dietary was given a dietary communication form on diet (change) to soft mech (mechanical)-chopped meat...Placed in restorative dining..."</p>	F 365	<p>F365 cont</p> <p>Measures or systematic changes put into place to ensure the deficient practice does not recur:</p> <p>In-service provided to 100% dietary staff per the Dietary Manager and the Registered Dietician on therapeutic diets and consistency of diets. To be completed by 09/30/12</p> <p>In-service will be added to the new employee orientation packet for dietary employees.</p> <p>Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:</p> <p>Beginning 09/12/12 dietary Manager will audit 15 trays per week x 8 wks</p> <p>to determine if the diet served is accurate for type and consistency per the physician order. Findings will be submitted monthly to the Quality Assurance Committee - who will determine the need for future focus.</p>		

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F 365	<p>Continued From page 7</p> <p>Medical record review of a document entitled "Rehab. Services Recommendations For;" dated February 15, 2012 revealed "...Restorative Nursing Program...eats too fast...will choke if...puts too much food in...mouth...diet is soft mech-chopped-no nuts, no food with peeling...Instructions...watch pt at mealtimes...If you leave...put tray aside & (and) then give back...Keep a visual eye on...at all times...3 times a day for 12 wks (weeks)..."</p> <p>Medical record review of a speech therapy screen dated February 16, 2012 revealed "...reported by CNAs (Certified Nursing Assistants) & restorative aids that (resident) has not had any episodes of choking and...doing well on soft mech-chopped meats and supervision at meals..."</p> <p>Medical record review of a speech therapy screen dated Friday, February 17, 2012 revealed "... (Diet change) for the weekend...decided to change (resident's) meat to puree for the weekend because restorative does not work on the weekend...to be in dining room for all meals with supervision. Pt's meat was changed because that seems to be the food that...crams into...mouth...On Monday I will change diet back to soft mech-restorative will be back on Monday (February 20, 2012)..."</p> <p>Medical record review of a nurse's note dated February 20, 2012 revealed the family discharged the resident to the home with plans for home health services.</p> <p>Telephone interview on August 21, 2012 at 12:10 p.m. with the Speech Therapist (ST) confirmed the ST had been informed the resident had</p>	F 365			

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F 365	Continued From page 8 "tendencies to choke at home" on meat and the ST "felt it was more appropriate at the nursing home to put...on chopped meat." The ST confirmed the resident required no assistance with eating but would place a "lot of meat on the spoon" and required supervision with eating. Continued interview revealed the restorative staff reported the resident "did really good if they sat with (resident)." Continued interview revealed the facility reduced restorative staffing from seven to five days a week-Monday through Friday, and the ST "was afraid...might get choked..." if left on a mechanical diet over the weekend. Continued interview confirmed the resident was placed on a puree diet for the weekend because the facility did not have restorative staff available, and the ST planned to resume a soft mechanical diet on Monday, February 20, 2012.	F 365			
F 441 SS-D	C/O #28341 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 Corrective action(s) accomplished for those residents found to have been affected: On 08/20/12 at 12:30p the DON assessed resident #3 and resident #7. There was no change in baseline from previous status as a result of dressing change procedure.. DON observed isolation precaution procedure for these residents per the staff providing care - compliance noted. How other residents having the potential to be affected were identified and corrective action(s) accomplished: Beginning on 08/20/12 at 1pm the DON conducted a nursing assessment on all residents that required treatment for a pressure or surgical wound. DON assessed each resident for any acute signs of infection or wound status changes - none were noted. This same residents were assessed daily x 3 for any acute signs of infections or wound status changes by the DON.	9/30/12	

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F 441	<p>Continued From page 9</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to ensure appropriate infection control was implemented during dressing changes and for prevention of possible cross contamination infections for two (#3 and #7) of eight residents reviewed.</p> <p>The findings included: Resident #3 was admitted to the facility on July 3, 2012 with diagnoses including Hypertension, Anemia, Cerebral Vascular Accident (Stroke), Obesity, Osteoarthritis and Severe Degenerative</p>	F 441	<p>F441 cont</p> <p>No symptoms were noted. Measures or systematic changes put into place to ensure the deficient practice does not recur: On 08/20/12 at 11a clean dressing change competency was completed with the wound care nurse per the DON. Beginning on 08/21/12 clean dressing change competencies conducted with all LPN and RN staff per the Risk Manager, DON or ADON. To be completed by 09/30/12. Change dressing change competency will be added to the new employee orientation pack for all LPNs and RNs. Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur: Beginning on 08/21/12 the DON or ADON will observe wound care/tx provided per the nurse 1 x week for 12 weeks to assure compliance with clean dressing changes - compliance with infection control measures to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. Findings to be reported monthly to the Quality Assurance Committee.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2012
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37680		
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F 441	<p>Continued From page 10</p> <p>Joint Disease with Right Total Hip Arthroplasty (June 29, 2012).</p> <p>Medical record review of a hospital operative report dated June 29, 2012 revealed "...history of severe functional limitations and pain secondary to...diagnosis of Osteoarthritis..."</p> <p>Medical record review of the Minimum Data Set (MDS) dated July 9, 2012 revealed the resident scored 9 of 15 on the Brief Interview for Mental Status (BIMS) with moderate impairment of decision-making skills; required extensive to total assistance with activities of daily living (ADLs); had almost constant pain; received scheduled and as needed pain medication; and rated the pain as "10" the worst pain imagined. Continued review of the MDS revealed the resident had a surgical wound.</p> <p>Medical record review of a nursing assessment dated July 3, 2012 revealed the resident had an incision on the right hip with staples.</p> <p>Medical record review of a physician's order dated August 14, 2012 revealed "D/C (Discontinue) order for hip incision...Cleanse (Right) hip (with) N/S (Normal Saline) apply Mupuricin (Mupirocin-antibiotic) oint (ointment). Cover (with) telfa & (and) secure (with) 6 (inch) x (by) 6 border gauze..."</p> <p>Medical record review of a nurse's note dated August 18, 2012 (Saturday) at 9:30 p.m. revealed "This nurse was told by CNA (Certified Nursing Assistant) that res. (resident's) previous surgical wound was draining a large amount...observed a dark green fluid leaking from top of previous</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2036 STONEBROOK PLACE KINGSPORT, TN 37660		
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F 441	<p>Continued From page 11</p> <p>incision. (Family) was in the room & demanded for res (resident) to be sent to hospital "to get something done." Continued review revealed the physician was notified and orders were received to transfer the resident to the hospital.</p> <p>Medical record review of the emergency room record dated August 18, 2012 revealed "...had right hip surgery approx (approximately) 1 month ago and now has "hole" in the incision area which is draining green fluid...affected area is painful...has redness...swelling...Severity of symptoms is moderate...History suggestive of: Post Op Wound Infection...Would suspect MRSA (Methicillin-Resistant Staphylococcus Aureus)...Doxycycline (antibiotic)...100 mg (milligrams)...2 times a day..."</p> <p>Medical record review of laboratory results of a culture of the right hip dated August 18, 2012 revealed "...Moderate growth of Staphylococcus Aureus..."</p> <p>Medical record review of a Nurse Practitioner (NP) progress note dated August 20, 2012 revealed "... (Right) hip surg (surgical) site...(with) pinhole opening upper third of incision, draining purulent (indicates presence of bacteria) material (with) foul odor. Appears to be a pocket of purulence in under side of incision. Able to express large amt (amount) of purulent drainage. Wound then cleaned (with) NS & ABD (Abdominal) pad applied...barrier adhesive applied first...Wound infection..."</p> <p>Review of the facility's policy for a clean dressing change revealed "...Procedure...Create clean field with paper towels or towlette drape..."</p>	F 441			

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F 441	Continued From page 12 Observation and interview with LPN #1 on August 20, 2012 at 9:00 a.m. in the resident's room revealed LPN #1 applied gloves; removed the dressing dated August 19, 2012 which was saturated with a large amount of green drainage with a foul odor; and then without removing the gloves, touched the call light to get help with positioning the resident. Interview with LPN #1 at the time of the observation confirmed the wound was infected and confirmed the LPN removed the soiled dressing and touched the call light without removing the soiled gloves. Continued observation revealed the LPN removed the soiled gloves and removed supplies for wound care from the treatment cart. Observation revealed LPN #1 placed the supplies including Granulex spray, Mupirocin ointment, wound cleanser and gauze on the resident's bed without a barrier. Continued observation revealed LPN #1 cleansed the right hip wound; removed the gloves and donned clean gloves. LPN #1 placed Mupirocin ointment on the gloved index finger; applied the ointment to the wound; then replaced the cap on the Mupirocin ointment without removing the soiled gloves. Observation revealed LPN #1 placed the Mupirocin ointment on the over-bed table without using a barrier. Observation revealed the LPN then removed the soiled gloves; donned clean gloves and applied a gauze bandage to the wound. The LPN removed a dressing from the right heel; cleansed the wound; applied Granulex spray to gauze; placed the Granulex spray on the over-bed table without using a barrier; and applied the gauze to the wound. The LPN removed the soiled gloves; washed the hands; and placed the Granulex spray can on top of the treatment cart and the	F 441			

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F 441	<p>Continued From page 13</p> <p>Mupirocin ointment in the uniform pocket. The LPN then placed the can of Granulex spray in the treatment cart aside eleven other cans of Granulex. The LPN then removed the Mupirocin ointment from the uniform pocket and placed the ointment in the treatment cart.</p> <p>Interview on August 20, 2012 at 10:25 a.m. in the hallway with LPN #1/Treatment Nurse confirmed the eleven cans of Granulex spray in the treatment cart belonged to individual residents. Continued interview confirmed the can of Granulex spray and Mupirocin ointment belonging to resident #3 (with an infected wound) was placed on the resident's bed and over-bed table without a barrier; then the Granulex was placed on top of the treatment cart and then in the drawer next to cans belonging to other residents with wounds. Continued interview confirmed the Mupirocin ointment was placed in the uniform pocket of LPN #1; removed from the pocket; and then placed back in the treatment cart with supplies used for other residents with wounds.</p> <p>Resident #7 was admitted to the facility on August 2, 2012 with diagnoses including Varicose Leg Ulcer, Depressive Disorder, Alzheimer's Dementia, Cerebrovascular Accident (Stroke), Osteoporosis, Edema, Pressure Ulcers and History of Right and Left Total Hip Replacements.</p> <p>Medical record review of the initial nursing assessment dated August 2, 2012 revealed the resident was admitted with a Pressure Ulcer on the right hip, the right ankle and heel and with a partial Amputation of the left great toe.</p> <p>Medical record review of the MDS dated August</p>	F 441			

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F 441	<p>Continued From page 14</p> <p>12, 2012 revealed the resident had short and long-term memory problems and severely impaired decision-making skills; had behavioral symptoms directed toward others (example: hitting, kicking, pushing, scratching, grabbing); was totally dependent on staff for all ADL; was assessed at risk for the development of Pressure Ulcers; and had two Stage 2, one Stage 3 and one Stage 4 Pressure Ulcers.</p> <p>Medical record review of a final "critical" laboratory report dated August 19, 2012 for a wound culture of the right hip (collected on August 13, 2012) revealed "...Moderate (3+) Escherichia coli (intestinal bacteria)...Many (4+) Proteus mirabilis (intestinal bacteria)...Many (4+) Staphylococcus aureus-Methicillin...Methicillin Resistant Staphylococcus aureus isolated...Moderate (3+) Enterococcus Faecalis (intestinal bacteria)..."</p> <p>Medical record review of a NP progress note dated August 21, 2012 revealed the NP had knowledge of the laboratory report dated August 19, 2012; spoke with the physician about the results and "...probable contamination and/or colonization of wound. Will continue to monitor for acute (changes) which signify infection. Cont. (Continue) current wound care measures."</p> <p>Observation on August 20, 2012 at 10:25 a.m. of LPN #1/Treatment Nurse providing wound care revealed the resident was lying in bed with an air mattress in place. Observation revealed LPN #1 removed wound care supplies from the treatment cart including Granulex spray, Santyl ointment (use for debridement of wounds), Algicell pads (dressings used to absorb large amounts of</p>	F 441			

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F 441	<p>Continued From page 15</p> <p>wound drainage) and placed the supplies on the resident's bed without placing a clean barrier on the bed. Continued observation revealed LPN #1 performed wound care on the right ankle and left great toe using Granulex spray. Observation revealed when LPN #1 finished applying the Granulex, the container of Granulex was placed on the over-bed table without a barrier. Observation revealed LPN #1 removed the dressing from the right hip which revealed eschar (slough) and a foul odor. Observation revealed LPN #1 performed wound care to the right hip with Santyl ointment and after applying the ointment placed the Santyl on the resident's bed. Observation revealed the LPN then placed the Santyl in the uniform pocket; left the room to open the treatment cart; re-entered the room; and placed the Santyl on the over-bed table without a barrier.</p> <p>Interview on August 20, 2012 at 11:10 a.m. in the hallway with LPN #1 confirmed both residents #3 and #7 had infected wounds and confirmed the Granulex, Algicell, Santyl and dressings for resident #7 were placed on the bed without a clean barrier and the Granulex and Santyl were placed on the over-bed table without a clean barrier after being used during the treatments. Continued interview confirmed Santyl was placed in the uniform pocket before being placed back on the treatment cart. Continued interview confirmed Granulex and Santyl were placed back in the treatment cart without being cleaned and LPN #1 was aware of the risk for cross-contamination.</p> <p>C/O #29207</p>	F 441			